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Original Communication

Safe in our hands?: A study of suicide and self-harm in asylum seekers

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Abstract

This study examined the incidence of suicide and self-harm in asylum seekers in the UK, both those in detention and in the community. The investigation revealed that data recording is seriously flawed or sometimes non-existent. However, the scanty data those were available from Immigration Removal Centres, coroners' records and Prison Ombudsman's reports showed high levels of self-harm and suicide for detained asylum seekers as compared with the United Kingdom prison population. It is suggested that this could be attributed to routine failure to observe and mitigate risk factors. The author makes the following recommendations: coroners should record asylum seeker status and ethnicity of deceased, self-harm monitoring in the community should record asylum seeker status and ethnicity, health care in immigration removal centres should meet the same standards as UK prisons as a minimum, allegation of torture by immigration detainees should trigger a case management review and risk assessment for continued detention, and this process should be open to audit, and interpreters should be used for mental state examinations unless their English has been shown to the fluent.

Keywords: Suicide; Self-harm; Asylum seeker; Refugee; Detention

Definitions. *Asylum seeker:* According to the 1951 Convention, 'a person having a well-founded fear of being persecuted for reasons of religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country'.

The term '*refugee*' is widely used to describe displaced people all over the world. In a legal context in the UK, a person is a refugee only when the Home Office has accepted their asylum claim. While a person is waiting for a decision on their claim, she/he is called an asylum seeker.

1. Introduction

The identification of at risk groups for suicide and the reduction of risk factors is a stated government strategy[1] and a key performance indicator in the prison system.[2] Whilst the UK national rate for suicide is 9/100,000 the rate for prisoners is 122/100,000. The risk groups identified by the government publication 'Suicide is Everyone's Concern', are: young adults, male gender, low income, previous traumatic experiences, contact with mental health services and lack of social supports. Asylum seekers carry not just one or two of these risk factors, but the majority of them as summarized in Table 1. The actual incidence of self-harm or suicide in this population is not known. Detention per se increases the risk of suicide and self-harm, and the rates for this in the UK's detained population are a matter of recognized concern.

Asylum seekers may be detained on entry to the UK, as part of the fast-track asylum process, and kept in detention for much or all of the process. Victims of torture and others may be deemed unfit for detention on medical grounds and released on 'temporary admission'. Other reasons for detention are after conviction for travelling with false documents, and after losing a claim for asylum, prior to removal. Statistics on the relative numbers in each category are not available. Foreign nationals detained in immigration removal centres prior to deportation are not included in this study.

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Table 1

Demography of asylum seekers in the UK
• 75–80% male
• 70–80% aged 18–35[a]
• Up to 30% victims of torture[b]
• Traumatic experiences common
• Barred from employment
• Receive 30% less benefit than residents

[a] Home Office Statistical Bulletin Asylum Statistics 2005, Prepared by Immigration Research and Statistics Service ISSN 1358-510X.

[b] Modvig J, Jaranson J. A global perspective of torture, political violence and health. In: John P Wilson, Boris Drozdek, editors. Broken Spirits: the treatment of PTSD in asylum seekers and refugees. New York: Brummer Routledge Press; 2003.

Asylum seekers living in the UK may have no knowledge of the fate of their family members left behind, have no family or social support in the UK, face the ongoing stress of awaiting a decision on their asylum application, in the face of the fear of being returned to the country from which they fled. Unsurprisingly the levels of mental illness in this group are thought to be high, but treatment and compliance rates may be much lower than they should be. It is difficult for asylum seekers to register with a GP, difficult for them to access therapeutic services without fluency in English and difficult for them to attend appointments regularly when they are moved frequently from one accommodation to another.[3,4] There may also be a relative lack of 'help-seeking behaviour' in this group for reasons such as culturally different perceptions of what is mental illness, the stigma in some cultures of mental illness or lack of money to pay for travel to appointments and for prescriptions. A number suffer from conditions such as post-traumatic stress disorder (PTSD), which is thought to induce an intrinsically reduced help-seeking behaviour, perhaps as an avoidance manifestation.[5]

Reviewing the existing literature shows it can be difficult to make comparisons, as some have studied 'refugees', which can mean all those fleeing persecution or only those with the right to remain in that country. Other research has studied asylum seekers or total immigrant populations. In the following paragraph, the terms used are those used by the authors. A review in the Lancet in 2005[6] studied the prevalence of serious mental health disorder in refugees settled in Western countries and found a probable 10-fold increase in PTSD prevalence, while a study by Steel et al. in 2006 found an independent adverse effect of immigration detention on the mental health of refugees.[7] An Australian study found very high rates of suicide and self-harm in asylum seekers in detention and, consequently, Australia has now given up mandatory detention because of the damage to their health.[8,9] The percentage of refugees who have been tortured is not known, though a range from 5% to 30% is often quoted.[10] Recent work has suggested an incidence as high as 55%.[11] Previous trauma, such as torture, is linked to an increased incidence of post traumatic stress disorder and of suicide.[12] In patients with a psychiatric diagnosis, especially PTSD, suicide is increased.[5] A Swedish study found the risk of an immigrant dying of suicide to be 1.5 times higher than for a native Swede,[13] (taking all immigrants, not necessarily asylum seekers), though this finding has not been replicated elsewhere.[14] An excellent review of suicide in ethnic minority groups in the UK found important risk factors to be recent contact with mental health services and psychiatric diagnosis.[15] Given the very high incidence of risk factors it is necessary to establish the rates of self-harm and suicide in asylum seekers in the UK and to urgently put in place the required treatment and support if we are to prevent further suicide and self-harm.

2. Method

To examine, the available data on suicide and self-harm in asylum seekers in detention and in the community proved to be a more difficult task than had been anticipated. Most of the relevant data are not being recorded at all. While very comprehensive statistics are available on many aspects of this problem for the detained UK population as a whole, these data do not include asylum seekers in immigration removal centres. Some of these general data have been used to make comparisons but the detained population does not really form an appropriate control group. Prisoners in the UK may be convicted or on remand, and there are important differences in their patterns of self-harming behaviour, with those on remand (a proportion of whom will be found innocent) showing higher incidence of self-harm.[2] In both groups self-harm risk is highest in the first 48 h of detention.

Those detained in immigration removal centres are a mixed group. About 70% are failed asylum seekers awaiting removal, but up to 30% may be foreign nationals who have served a sentence in the UK and are now awaiting deportation. Asylum seekers detained in mainstream prisons may be on remand, convicted of a crime committed within the UK or convicted of immigration offences such as travelling without valid travel documents. The available data on self-harm in prisons, while these do distinguish between remand and convicted prisoners, do not distinguish between these latter categories or between UK nationals, foreign national prisoners and asylum seekers.

Different ways of accessing data and information in the target group were explored. There are no data on asylum seekers' self-harm rates in the community, as accident and emergency departments do not code patient episodes for asylum seeker status.

Self-harm data are available for prisons and for the Immigration Removal Centres, both as total numbers and as an expression of risk, in the form of numbers of self-harm monitoring forms opened. These forms, known until recently as SASH forms are initiated by staff after a self-harm incident or if a detainee is thought to be at significant risk of self-harm. Thus, in an ideal situation, the numbers of SASH forms should greatly outweigh the numbers

Table 2
Data collected on each self-harm case

Age
Gender
Country of origin
Date of arrival in UK
Location of family or social support
Stage of asylum claim
Date of any removal directions[a]
Any history of trauma including torture
Mental health history
Medication
Drug and alcohol use
Contact with mental health services
Detention in the UK or country of origin
Previous self-harm history
Nature of self-harm
Mental state assessment
Date of self-harm risk form if raised

[a] The order to leave the country after a claim is lost.

of actual incidents, because the heightened awareness of risk has triggered appropriate actions by staff. Both figures will, however, be affected by the numbers of new receptions in a detention centre. A centre with a high throughput of short stay cases will be expected to have higher incidence than a centre with a more stable population. These data will be discussed below.

A pilot study was made to study clinical records relating to those who had self-harmed in an immigration removal centre. Data recorded are listed in Table 2.

This pilot study was abandoned as it became clear that it was not possible to see either all the records for a given time period, or a random sample, as only some of the clinical records remained at the centre and there was no clear reason why some were retained and others had not been. In general, records are sent on with the detainee to their next place of detention, but not all those retained were of those who had been released from detention. Since there was no discernible pattern, and the records available were only a small fraction of the total number of cases recorded as self-harming, no representative study could be made.

An alternative approach was to study the suicides of asylum seekers and analyse the records for presence of known risk factors. To do this, permission was sought from individual coroners who had been involved in such inquests. There were problems in accessing these data, which will be fully discussed below. Data recorded about each death studied were the same as in Table 2. Limited analysis of these data are made below.

3. Results

3.1. Self-harm

Results of analysis of the data available on immigration removal centres (IRC).

From 1.4.05 to 31.3.06, 231 incidents of self-harm requiring medical treatment in IRCs were recorded by the Home Office. The average population of these IRCs is 1806 (number detained as at 31.12.05, includes foreign nationals as well as asylum seekers) This gives a estimated percentage self-harming of 12.79%, assuming only one incident per prisoner, but records do not indicate if this can be assumed. Actual self-harm numbers may be higher, as this only represents those presenting for medical treatment of the self-harm injury.

For comparison, UK prison data for the same period give rates of self-harm between 5% and 10%. There are variations between men and women, sentenced and remand prisoners. Women in UK prisons are suffering nearly 50% of all self-harm, but are <6% of prisoners. These figures are based on self-reported numbers self-harming as a percentage of the average population in prisons and derive from an extensive survey performed in 1997 for the ONS Psychiatric Morbidity among Prisoners.[16] In IRCs, it is not recorded how many women self-harm. Women form 10–14% of detained asylum seekers. Data comparison is also hampered by differences in recording-multiple episodes in the same individual or only per individual.

3.2. Suicides in prison and in IRCs

The prison data available for 1997–2005 are expressed as deaths per 100,000 using the average prison population not the total throughput. The average is 122 per 100,000 while the UK national rate for this period is 9 per 100,000.

Some asylum seeker's deaths have occurred in mainstream prisons rather than IRCs, but the victims were in detention for immigration offences, and so have been included. Figures for total asylum seekers in detention are taken from the Home Office Statistical Bulletin Asylum Statistics 2005 (Table 3).

Table 3
Suicide rates for asylum seekers in detention 1997–2005

Year	Suicide	Institution	No of asylum seekers in detention	Suicide rate/ 100,000
1997	0		787	0
1998	1	HMP Brixton	860	116.3
1999	0		741	0
2000	1	Harmondsworth IRC	741	134.9
2001	0		1280	0
2002	1	HMP Lewes	795	125.8
2003	1	Haslar IRC	1285	233.5
	1	HMP Bedford		
	1	HMP Belmarsh		
2004	1	HMP Leicester	1515	264
	1	Colnbrook IRC		
	1	Harmondsworth IRC		
	1	Dungavel IRC		
2005	1	Campsfield IRC	1450	137.9
	1	Yarls Wood IRC		
MEAN	1.33		1050	112.5

With such small numbers, a single digit increase or decrease makes a large difference to the rate expressed per 100,000. Thus it may be felt that the 3-year aggregate, calculated by adding deaths in a 3-year period, dividing by total detained in the same period and multiplying by 100,000 gives a more accurate impression. Tables 4 and 5.

There is a total of 12 deaths of asylum seekers in the 7-year period closest to that of the prison statistics. The trend shows a probable increase in suicide rate as the detained population increases. It could be argued that this follows a similar trend to that seen in the prison population as a whole, where suicide rates increased with increasing population, reflecting overcrowding in prisons and lack of trained staff.[2] The UK's prison population increased steadily from 1997, when it was 61,467 with suicide rate of 111 to 74,468 in 2004 with suicide rate of 127.[17] In making comparisons with the prison population, it should be remembered that the detained asylum seekers have not committed a crime. Those asylum seekers convicted of criminal offences and foreign nationals not known to be asylum seekers have been excluded.

Of these 12 deaths coroner's records were made available in six cases and the Prisoners Ombudsman's report in a further three. Of the remaining three cases, access to records was not possible due to one set of coroner's records being lost and in two cases to lack of response by the coroner's office.

The data collected according to factors listed in Table 2 give valuable information about these deaths. Data were also collected on suicide deaths of asylum seekers in the community and these data together with those from the detained cases are reported below.

3.3. Results from the coroners records and Prisoners' Ombudsman's reports

Thirty-eight suicide deaths of asylum seekers occurring between January 2000 and December 2005 were identified from a list prepared by IRR News Network in 2006.[18] Of these, 35 were male and three female.

Only 22 of the 38 cases could be analysed in detail from the coroners' files or Ombudsman's reports. Reliable data could not be obtained for the other cases.

Demography of asylum seeker suicides

- Age range 18–79.
- Mean age 31.
- 21 male, 1 female.
- Detained asylum seekers – mean age 27.
- UK prisoners have a similar age/sex profile, with an age range from 17 to 62, 57% being less than 30 years old and 97% male.[2]
- All the detention deaths were male and only 1/22 deaths were female.

The average age of prison suicides in the UK (from 1996/7 data in Suicide are Everyone's Concern, HM Inspector of Prisons) ranges from 17 to 62 with 57% <30 years old. 97% were male.

Nationalities of the suicides studied is shown in Table 6. The nationality that emerges as of highest concern in this study is Iran. Iranians comprise 12% of asylum seekers and 11% (second highest frequency country of origin) of cases seen at the Medical Foundation for the Care of Victims of Torture (personal communication), but they are below average in terms of getting an initial favourable decision on their claim, at 14% compared to an average of 17%. The national suicide rate in Iran does not appear to be exceptionally high, recent data give 6.17/100,000[19] (2000–2001), comparing to the UK national rate of 9/100,000.

Table 4
Triennial aggregated detained asylum seeker suicide rates

3 Year period	Rate/100,000
1997–1999	42
1998–2000	85
1999–2001	36
2000–2002	71
2001–2003	119
2002–2004	222
2003–2005	211

Table 5
Detained asylum seeker suicide rate and detainee population 1997–2005

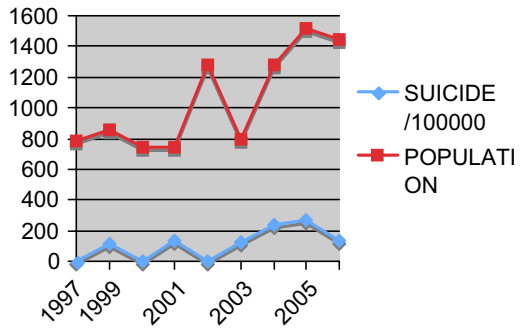
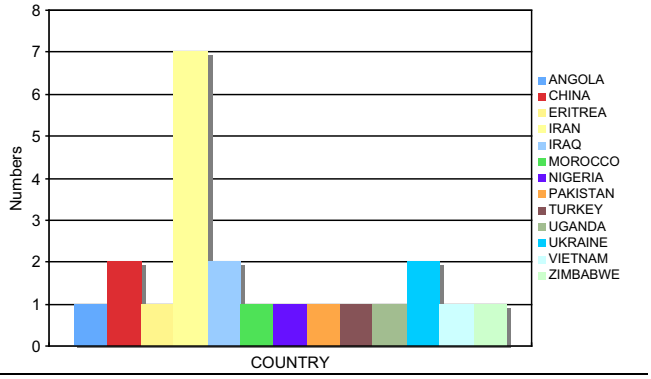


Table 6
Asylum seekers suicide deaths by country of origin 2000–2005



If we take the total number of Iranians (principal applicants) claiming asylum over the last 6 years as 21,140 (HO Asylum statistics 2005), then the suicide rate in this group is 33.1 per 100,000.

4. Methods of suicide

The analysis of the deaths of asylum seekers showed a majority died by hanging, Table 7. Of the deaths of asylum seekers occurring in detention, all except one were due to hanging, and that one involved jumping while a ligature was around the neck, but death was due to the head injury sustained in the fall. UK detention figures from Suicide is Everyone's Concern, using data gathered from 1996/7, shows 90% of prison suicides were by hanging.

4.1. Marital status and social isolation

The majority of asylum seekers are single and remain so during the process of seeking asylum, but it was not always clear from the records whether or not they had a partner in the UK. Table 8 records social isolation.

4.2. Detention in country of origin

Again, this history was not always noted in the records and little detail was available as to reason for detention and length of detention. Table 9 shows what is known of detention history.

4.3. Victim of torture or organized violence

These data are shown in Table 10. Those cases where a specific note in the records indicates an allegation of past torture comprise a third, but nearly half of the cases did not indicate either way if torture had occurred in the individual's past. The immigration records containing statements regarding the claim are a very useful source of this information but they are not usually included in the coroner's files. The high number of unknowns reflects the nature of inquests: that the coroner's duty is principally to determine the immediate cause of death not the prior potential risk factors. The same applies to the 'reason for flight' below:

Four out of nine detained asylum seeker suicides had disclosed a history of torture and two of the other five showed no record of the question being asked, as it should be (rule 33, IRC operating standards[20]).

4.4. Reason for flight from country of origin

The predominant reasons given by the individuals themselves are shown in Table 11. Both of the two cases citing sexuality as reason for flight were Iranian. Homosexuality is punishable by death under Iran's 1991 Islamic penal law.

4.5. Mental health history

Eighty-two per cent had a mental health history (Table 12), of which 72% had depression, 22% had psychosis and 6% had PTSD (Table 13). This finding is a little unusual in that asylum seekers in general are thought to have a relatively higher incidence of PTSD.

There were four episodes noted in records where referral to a psychiatrist had not been acted upon. There were five episodes noted in the records where no interpreter was used

Table 7
Methods of suicide

Method	Number
Hanging	16
Immolation	3
Jumping	2
Gunshot	1

Table 8
Social isolation

	Number ($n = 22$)	Percentage
Single	16	73
Living with first degree relative/partner in UK	2	9
Not known	4	18

Table 9
Detention history

	Number ($n = 22$)	Percentage
Not known	12	56
Detention	5	22
No detention	5	22

Table 10
Torture history

	Number ($n = 22$)	Percentage
Victim of torture	8	36
No torture history	4	18
Not known	10	46

Table 11
Reason for flight from country of origin

	Number ($n = 22$)	Percentage
Political	6	27
Sexuality	2	9
Fear of gang violence	2	9
Ethnicity	1	5
Religion	1	5
Not known	10	45

Table 12
Mental health history

	Number ($n = 22$)	Percentage
Mental health history	18	82
No mental health history	4	12

Table 13
Mental health diagnoses

Dignosis	GP/Psychiatrist	Opinion of friends/staff	Percentage
Psychosis	3	1	72
Depression	11	2	22
Post traumatic stress disorder	1	0	6

to aid assessment of mental health despite an indication that this was needed. Fourteen per cent of asylum seeker suicides had a history of drug or alcohol abuse.

4.6. Previous history of self-harm behaviour

A variety of methods were noted, see Table 14, but again there was a high percentage of cases where no self-harm was recorded, from which little can be drawn. It does not necessarily indicate that no self-harm occurred, only that no history of it was recorded.

4.7. Asylum seekers suicides in detention compared with UK prisoners

These data are summarized in Table 15 and show some marked differences between the two populations. In particular, in the asylum seeker group, the higher prior self-harm rate and contact with mental health services contrasts with the lower number with open self-harm forms at time of death.

4.8. Asylum decision and proximity to death

From arrival, through the process of application for asylum, refusal, lodging appeal, appeal decision and issuing of removal directions after final loss of an application, the timing of suicides in relation to these events was charted and is shown in Table 16.

Table 14
Self-harm methods

Method of self-harm ($n = 22$)	Number ($n = 22$)	Percentage
None recorded	10	45.5
Cutting	2	9
Punching/headbutting wall	2	9
Stabbing	1	4.5
Hanging	1	4.5
Overdose	1	4.5
Method not specified	2	9
More than one method	3	14

Table 15
Mental health of detainees

Suicides in detention	Asylum seekers	UK prisoners
Single	78%	57%
Prior contact with mental health services	67%	35%
Drug and alcohol history	0	73%
Prior self-harm history	44%	19%
Open self-harm form	11%	20%

Table 16
Relation of asylum decision to suicide

Proximity to death	Number ($n = 22$)
Within few days of designated removal date	**4**
After loss of appeal (no removal directions)	**8**
<2 weeks	*3*
>2 weeks, <3 months	*2*
Over 3 months	*3*
After initial refusal	**4**
Just after news of refusal	*1*
Just before appeal	*1*
No date for appeal	*2*
No clear evidence any asylum decision made	**5**
Had indefinite leave to remain, not informed of this	**1**

As stated above, it is not the work of the coroner to study the immigration papers and in most cases these were not included in the files. In those cases where it was clear what point in the asylum process the deceased had reached, there seems to be no greater linkage with any one particular stage than with any other. There is often testimony in the coroner's files from a number of witnesses that the deceased had gradually given up all hope and become increasingly depressed and isolated in the weeks before death. Alternatively, in some cases hope seems to be maintained to the last minute, and then an impulsive decision is made.

In the national data on prison suicides, just under half were in the first month of detention and about 30% within the first week. Forty-seven per cent of deaths were in remand prisoners who comprise <20% of the total detained population.

5. Discussion

5.1. Self-harm in detention

The available data point to a rate of 12.97% for detained asylum seekers while the mainstream prisoners' rates vary between 5% and 10%. Rates are higher in remand prisoners than after conviction, and most detained asylum seekers are at least equivalent to remand prisoners, in that they have not been convicted of any crime. One can go further, since in their own minds, most are not aware of having committed any crime (with the exception of those detained on immigration offences such as knowingly using a false passport). Thus it is perhaps not surprising that the rate of self-harm is very high in detained asylum seekers. It would be more informative to know the breakdown of these incidents by gender and if they represent repeated incidents in fewer individuals or one incident per detainee. It must also be remembered that *actual self-harm cases may be higher than those reported*, as reported cases tend to be only those referred to the health centre and requiring treatment. Anecdotally it is suggested that many self-harmers

do not attend for treatment. If the data were to be collected along the same lines as that for the prison population, more useful comparisons could be made.

It is of great concern that more is not known on this, as the link between self-harm and suicide has been extensively demonstrated.[21,22] Unfortunately, self-harm may still bear the stigma of being classified as attention seeking behaviour by some individuals.

Self-harm in the community by asylum seekers remains an unknown quantity as ethnic monitoring data in accident and emergency departments does not identify this group.

6. Suicides in immigration detention

The results shown here are stark: the average suicide rate in the UK is 9 per 100,000 and the prisoner suicide rate is 122 per 100,000, while this study shows the rate for detained asylum seekers to be 112 per 100,000 for the period 1997–2005 with a peak of 222 per 100,000 in the period 2002–2004.

Obviously these numbers are small and care must be taken not to read too much significance into such data. However, a great deal is known about prisoner suicides and some of this information can be utilized when looking at the deaths in immigration detention. As prison population rises the suicide rate rises. Prison overcrowding and staffing levels must clearly play a part in the identification and care of at risk detainees. Immigration removal centres in particular have a very high throughput of detainees, with many staying only a few days before passing to another detention centre, being released or being removed. For example, in the third quarter figures for 2005 (HO Gov statistics), while the number of asylum seekers in detention was 1450, 4285 were recorded as having left detention in that period. In fact, these centres are processing more detainees than this, as asylum seekers make up only around 75% of those detained in these facilities, i.e. total detainees leaving immigration detention for this quarter was 7265 with 1806 the average number in detention. Thus around 29,000 detainees per annum are received while at any one time numbers detained are only about 6% of this.

In Britain's prisons, the average number of prisoners for the years in this study varies between 66,000 and 76,000 with annual total receptions of 132–141,000. This gives a proportion of detainees to total receptions in the region of 50%. So while staff in prisons are receiving about twice as many detainees as they keep, the staff in immigration removal centres are processing very much greater numbers.

The effect of this pressure of work can perhaps be seen in the health care reception screening questionnaires used. The prisons use a multi page detailed assessment tool with a great many questions devoted to mental health, past and present and specifically aimed at not simply asking about presence or absence of suicidal thoughts but looking for risk factors such as social isolation and feelings of hopelessness and objective observations of the assessor as well as the subjective responses of the detainee. While a few of the IRCs use a similar extended assessment, most use brief versions. There are at least three different assessment tools in use, reflecting the differing health care providers working in the IRCs. The briefest health screen in use during this study period consisted of only four questions. The high throughput in the IRCs may also contribute to the relative lack of interpreter use and lack of continuity of healthcare delivery and record keeping.

A further concern in respect of the IRC deaths and differing standards to those of mainstream prisons are the two young men, under 21, who had been detained in centres with older adults for several months prior to their deaths. The files recorded impressions of isolated young men whom no one knew well. In UK, prisons under 21s have been normally detained with their peers and not with older adults. The specific legal status of under 21s has recently ended and the Chief Inspector of Prisons has expressed concern about the welfare of these young men.[23]

It should also be remembered that IRCs principally detain not criminals, but those who have lost their asylum claim. The fact that they have done so should not be taken as evidence that everything they say is untrue, but a culture of disbelief is apparent throughout the IRCs. Late disclosure of torture and other traumas tends to be discounted and no attention is paid to an individual's past history. It needs to be understood that a torture claim may well be true even though the claim has been lost for asylum, as the case has turned on other legal grounds.

6.1. Demographic data for the study

The original list of deaths came almost entirely from a list prepared by the Independent Race and Refugee News Network. They collected reports in local newspapers from all over the UK to compile this list. Of 38 suicides within the study period, I was able to check the details in 22 cases using coroners' files or Prisoners' Ombudsman's reports.

There is no way of knowing how many other asylum seekers' deaths in the community have occurred as the coroner cannot record this information – that the deceased is an asylum seeker – on the form sent for national statistical analysis. The form does record place and country of birth, but this of course does not indicate how long the deceased may have lived in the UK and with what status. There is a potential opportunity to record 'asylum seeker' in the space marked 'occupation', which would not be unreasonable as asylum seekers have no other occupation, having no permission to work. Two coroners who tried to do this reported that their forms were returned to them with instructions to change this information to 'unemployed'.

Recording the immigration status of deceased individuals, as well as their country of origin and ethnic group would add greatly to the available data and accuracy of research in this area. One case that came to light independently and by chance was that of a child asylum seeker. There is no way of knowing how many other cases are unreported.

Bennewith, Hawton et al.[24] reviewed the usefulness of coroner's data on suicides and found wide variation in information recorded. They recommended use of standardized forms. Several coroners noted that they felt they had seen more cases of asylum seekers suicides than listed in this enquiry, but they could not recall names and had no way of retrieving data without names. Local press reports were found during the course of this enquiry to be not always accurate as regards, nationality, age, asylum seeker status and past history so are not reliable as a full source.

The coroners' files do not routinely contain copies of the immigration notes often held by asylum seekers, or details of their legal representatives. If such information were routinely collected, permission might be sought to approach the solicitors for their files, which often contain valuable information including medico-legal reports and medical records.

A further constraint noted by some coroners was the time taken to arrange jury inquests, which have significant cost implications. In some cases, this meant that an inquest was not held until many months after the death. Asylum seeker witnesses are not necessarily easily traced at such intervals if questions further to their initial statements should arise, as they may have been dispersed or removed from the country.

7. Risk factors

The age and gender profile of suicides in this group is broadly similar to the national one, with the deaths occurring predominantly in young men.

The countries of origin revealed a disproportionate number of deaths in Iranians especially (and also in Afghans, although these data were in the unconfirmed group). High proportions of applicants from both these countries are refused asylum. It is possibly of note that the highest rate is in Iranians who have a below average chance of a successful claim while being a group seen frequently at the Medical Foundation for the Care of Victims of Torture, Afghans, who seem to have a better chance of gaining asylum, also have a high rate of suicide, but not as high. If being treated at the Medical Foundation might be taken as an indicator of previous torture and mental ill-health, to what extent does a negative decision on asylum application influence mental health? It is possible to speculate that where more Afghans for example are getting a favourable decision they may be coping better with their past traumas or be better able to access mainstream NHS treatment due to their refugee status. The Iranians, who are more likely to get a negative decision, seem to remain more vulnerable.

Social isolation is a known risk factor is suicides and given that the majority of asylum seekers reaching this country are single individuals speaking little or no English, this is likely to play an important part. The results here show seven out of nine detention deaths were in single men, and the majority of the total deaths were in single individuals. Many of the coroners' files studies showed a paucity of witness statements from anyone knowing the deceased well, and clearly a majority lived in isolation even if their accommodation was shared with other asylum seekers. Often there was no common language with which they could speak to their house-mates and a lack of interpreters in the locations to which they had been dispersed which made it difficult for them to register with GPs or communicate with any of those who might be able to help them.

History of prior detention was not recorded in most cases, so no inference can really be drawn in this regard. Similarly details regarding reason for flight or a history of being a victim of torture were not reliably recorded. This information would give much greater insight into the risks for individuals and could readily be obtained from the immigration documents such as the applicant's statement of claim, if this was routinely included in the coroner's investigations. Although the coroner's primary duty is only to investigate immediate causes of death, rule 43 of the Coroner's Rules[25] states that if there are circumstances that might continue to cause future deaths, the coroner has an obligation to investigate these. It can be argued that enabling better identification of at risk individuals by facilitating further research falls into this category.

For those in detention, a more detailed exploration of prior history including exposure to armed conflict, torture and other traumas would provide a better basis for suicide risk assessment. Immigration detention reception screening questionnaires do routinely ask if the person wishes to allege a history of torture. This complies with rule 33 of the IRC operating standards. The allegation of torture forms however do not go into any detail of the torture or what effect it may have had or continue to have on the victim. The basis for this rule is laudable, in that it is intended to prompt a reassessment of the individual's fitness for continued detention, based on the evidence that victims of torture may suffer severe and enduring ill health as a result, and that their condition can be made worse as a result of further detention. Specifically victims with PTSD tend to suffer more intensely from intrusive recall and flashbacks of their previous detention experiences when detained again. In reality, this is a paper exercise in which forms containing few specific details are forwarded by the centre manager to the Home Office but there is no detectable onward path, no evidence of case review on the basis of the information in the forms or outcome measure.

Mental health history was prevalent in the great majority of cases, again in line with risk factors identified nationally in the UK. What is of concern here is the identification of cases where psychiatry referral was advised but not carried out, mental state assessments were frequently carried out without interpreters in patients with very limited use of English and psycho-active medication prescribed in the community was not maintained while in detention. Continuity of medical records for detainees undergoing multiple transfers between different detention centres was poor. Even if a self-harm attempt was logged on the form accom-

panying a detainee to a new detention centre, there would generally be no details of the full mental state assessment and management plan.

In the detention deaths group, use of self-harm at-risk forms was lower in this group than in prison suicides, while prior contact with mental health services was higher in this group than in prison suicides. This is of great concern, indicating as it does some serious procedural flaws in the assessment process and monitoring of at risk individuals in IRCs.

Drug and alcohol history was markedly low in this group, particularly in comparison with prison suicides. This may be a reflection of religious and cultural prohibitions and is certainly the most clear-cut difference between the detention and community asylum seeker suicides and those by UK residents generally.

Prior self-harm behaviour is a known risk factor for suicide and is more prevalent in the asylum seekers, both detained and in the community than in the UK prison population, where rates are recognized to be high.

Method of suicide was very similar to that found in the UK generally, with the commonest method while in detention being hanging. The reports into the detention deaths repeatedly comment on a number of points in this regard, particularly: training of staff in risk assessment, continued monitoring of those on at risk forms, reducing potential ligature points in cells and other parts of the detention centre. Of perhaps greatest concern is that not all staff carry a ligature knife causing delay in cutting down victims.

Asylum decision and proximity to death does not show a strong relationship in either the detained or the non-detained group. Although numbers are perhaps too small to draw firm conclusions from this, the inference is that many factors probably interact in a person's decision to commit suicide. A number of the files recorded a gradual descent into deeper depression following a negative asylum decision, but other suicides were probably impulsive. In some cases it would seem that, tragically, the asylum process may not have been properly understood, in that the victims gave up hope before their appeal was heard, but this may also reflect an independent progression of their mental illness and a lack of social support.

Two cases did very clearly indicate a lack of understanding of the asylum issues: in one the victim was serving a sentence for travelling under a false passport and on being told that he was to be moved to a different prison, apparently believed that he was going to be removed to his country of origin. No interpreter was used when he was given this information. In another case, the victim was served a notice to quit his accommodation but believed that this meant his claim was lost and so killed himself. In fact he had been given refugee status but had not received the letter, so although the reason he was being given notice to quit was due to the change in his asylum status he did not know this.

A particular reason for focusing on the timing of removal directions or loss of the asylum case with respect to the suicide is the case of 'J'.[26] In this case a man whom two psychiatrists have termed vulnerable and suicidal has declared that he would kill himself rather than return to his country of origin and risk further torture. While the psychiatrists agree that this is a serious risk, the House of Lords determined that so long as adequate care is given to prevent his committing suicide until the plane touches down in his home country, this is no reason to change the decision that he should be removed. The Home Office has stated that adequate care to prevent suicide can be given from the moment of serving removal directions until the man is handed over to immigration in his home country. In this study an almost identical case emerged: two experts had written reports stating that X was vulnerable and suicidal. X said that he would kill himself rather than be returned to his country and the experts agreed that there was a very serious risk of his carrying out that act. He lost his case, and killed himself. While clearly it would be impractical to suggest round-the-clock monitoring of every refused asylum seeker, in those specific cases where two experts agree that there is serious concern regarding a patient's mental health, it would seem that at the very least it is inaccurate for the Home Office to state that refusal will not precipitate suicide on the grounds that adequate care can and will be taken to prevent it.

8. Conclusion

In almost every case analysed, there were large gaps in what was known about the victim. A reticence in asking questions by those in positions of authority and in particular those assessing mental health was a recurring theme. In some immigration removal centres, health care staff stated that they specifically avoid asking direct questions about past traumatic events and about suicidal acts or thoughts in case the person becomes upset. Although training in suicide risk assessment now teaches that it is more important to ask these questions and make a full assessment than not to do so, this old attitude still prevails in many settings.

If up to 30% of asylum seekers have been tortured, and a majority of torture victims suffer some form of mental illness as a result, principally depression and post traumatic stress disorder, both associated with an increased risk of suicide, then the mental health needs of this group should not be underestimated and the potential for prevention of suicide by improving health assessments in detention and access to mental health care in the community is very real.

Although this study has shed some light on the issue of suicide and self-harm in asylum seekers, a great deal is still left unknown. We know that asylum seekers in detention are more prone to self-harm than other prisoners. We know that they are much less likely to be doing so on a background of drug and alcohol abuse but are more likely to have a recent history of contact with mental health services. When in detention, they are less likely to have had the risk of self-harm noted prior to their death. The lack

of consistent use of professional interpreters is a major concern here. Too many times staff relied on broken English or the offer of another inmate to translate.

We still do not know how many asylum seekers in the community commit suicide, how many self-harm, and of those who do, how many have identifiable risk factors in their history which could have triggered significant opportunities for prevention.

The author makes the following recommendations: coroners should record asylum seeker status and ethnicity of deceased, self-harm monitoring in the community should record asylum seeker status and ethnicity, health care in immigration removal centres should meet the same standards as UK prisons as a minimum, allegation of torture by immigration detainees should trigger a case management review and risk assessment for continued detention, and this process should be open to audit, and interpreters should be used for mental state examinations unless their English has been shown to be fluent.

It is clear from this study that government institutions are failing in their duty of care to those who have sought refuge in this country, and that they are not 'safe in our hands'.

References

1. National Suicide Prevention Strategy for England, Dept. of Health, April 2002.
2. Suicide is Everyone's Concern. A thematic review by HM Chief Inspector of Prisons for England and Wales, 1 May 1999.
3. Burnett A, Peel M. Asylum seekers and refugees in Britain. *BMJ* 2001;**322**:547–54.
4. McKenzie K, Serfaty M, Crawford M. Suicide in ethnic minority groups. *Editorial B J Psychiatry* 2003;**183**:100–1.
5. Mezey G, Robbins I. Usefulness and validity of post traumatic stress disorder as a psychiatric category. *Br Med J* 2001;**323**:561–3.
6. Fazel M, Wheeler J, Danesh J. Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *Lancet* 2005;**365**(9467):1309–14.
7. Steel Z, Silove D, Brooks R, Momartin S, Alzuhairi B, Susljik I. Impact of immigration detention and temporary protection on the mental health of refugees. *Br J Psychiatry* 2006;**188**:58–64.
8. Contradictory Australian national policies on self-harm and suicide: the case of asylum seekers in mandatory detention. *Austr Psychiatry,* 2003;**11**(Suppl. 11)pS102–8, Blackwells ISSN: 1039–8562.
9. Fazel M, Silove D. Detention of refugees. *Editorial BMJ* 2006;**332**: 251–2.
10. Baker R. Psychological consequences for tortured refugees seeking asylum and refugee status in Europe. In: Basoglu M, editor. *Torture and its consequences: current treatment approaches*. Cambridge (UK): Cambridge University Press; 1992. p. 83–101.
11. Jaranson JM, Butcher J, Halcon L, Johnson DR, Robertson C, Savik K, et al. Somali and Oromo refugees: correlates of torture and trauma history. *Am J Public Health* 2004;**94**(4):591–8.
12. Bruce SE et al. Trauma and post traumatic stress disorder in primary care patients. *J Clin Psychiatry* 2001;**3**(5):211–7.
13. Ferrada-Noli M. A cross-cultural breakdown of Swedish suicide. *Acta Psychiatr Scand* 1997;**96**:108–16.
14. Malenfant EC. Suicide in Canada's immigrant population. *Health Rep* 2004;**15**(2):9–17.
15. Hunt I et al. Suicides in ethnic minorities within 12 months of contact with mental health services: National clinical survey. *BJPsych* 2003;**183**:155–60.
16. Singleton N, Meltzer H, Gatward R. Psychiatric morbidity among prisoners in England and Wales, Office for National Statistics ISBN 0-116210-45-1.
17. Bromley Briefings Prison Factfile, Prison Reform Trust, April 2006.
18. Driven to Desperate Measures, Institute of Race Relations, 2006.
19. Akbari ME, Naghavi M, Soori H. Epidemiology of deaths from injuries in the Islamic Republic of Iran. *Eastern Meidterranean Health J,* 2006;**12**(3–4):382–90.
20. Operating Standards for Immigration Service Removal Centres, Immigration and Nationality Directorate, Home Office.
21. Hawton et al. Deliberate self-harm: systematic review of efficacy of psychosocial and pharmacological treatments in preventing repetition. *BMJ,* 1998;**317**:441–7.
22. Owens D, Horrocks J, House A. Fatal and non-fatal repetition of self-harm: systematic review. *Br J Psychiatry* 2002;**181**:193–9.
23. Annual Report of HM Inspector of Prisons 2004–2005, HM Inspectorate of Prisons 2006. Stationery Office, London.
24. Bennewith O, Hawton K, Simkin S, Sutton L, Kapur N, Turnbull P, et al. The usefulness of coroners' data on suicides for providing information relevant to prevention. *Suicide Life Threat Behav,* 2005;**35**(6):607–14.
25. Coroner's Rules 1984, SI 1984 No. 552, Rule 43: Prevention of similar fatalities.
26. Case of 'J' and Secretary of State for the Home Department, Court of Appeal Case no. C4/2004/2432.